III. State Overview

A. Overview

PROCESS TO ESTABLISH TITLE V NEEDS AND PRIORITIES:

Montana's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Montana's MCH population. The Title V Program functions within the Family and Community Health Bureau (FCHB) in the Public Health and Safety Division (PHSD) of Department of Public Health and Human Services (DPHHS). The Title V activities support Montana's MCH population issues and needs. Bureau activities include reviewing epidemiological data and information from stakeholder and public input activities, ensuring state and local staff are adequately trained in MCH program and policy development, development and implementation of evidence based programs and services addressing the health needs and risks impacting the MCH population, partnering to develop client services data systems and quality assurance for service delivery, and communicating regularly to manage the Title V Program at both the operational and population health levels.

During FY2009, in preparation for the Maternal and Child Health Block Grant (MCH BG) application, Montana conducted an assessment of the health needs of women, infants, children, adolescents, and children with special health care needs in the state. The assessment consisted of various components including a review of subjective and objective data with state and local parties to ensure coordination of services. The assessment consisted of consumer input through focus groups, key stakeholder interviews, and professional judgment from those working in the field. The needs assessment process and resulting priority areas are more fully described in other sections and in the 2010 MCH Needs Assessment document, which is included with the 2011 application. The 2010 MCH Needs Assessment is a valuable tool for guiding the state's current and future MCH Block Grant applications.

Montana utilizes the Public Health System Improvement Taskforce (PHSI TF) as the advisory group which assists state staff to examine data and develop plans. The PHSI TF was created in 1993 and is responsible for implementing a statewide strategic plan for public health, developing policy recommendations and advocating for public health (PHSI TF Charter). The PHSI TF also serves as advisory for the preventive health block grant.

The FCHB's role in addressing these priority areas is through the major functions of public health, which are assessment, policy development and assurance. The Bureau may serve primarily to inform partners about the issue (assessment), may establish programs and services to address particular issues (policy development), and/or may work with public and private partners to facilitate access for the MCH population to needed services (assurance).

INTRODUCTION: Montana's geography, nature of her minority groups, political jurisdictions, economic characteristics, population size and distribution have a profound effect on the health of her citizens, how direct and public health services are provided, and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives and the process for determining those priorities.

GEOGRAPHY: Montana is the fourth largest state in the United States, encompassing 145,552 square miles, 56 counties, and 7 Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and has several state parks and state forest areas. The eastern two-thirds of the state are semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches.

ENVIRONMENTAL CONCERNS: Montana's environmental history includes extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas, lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues.

However, these extraction processes have left a legacy of environmental pollution. In 2010, Montana had 15 Federal Super Fund sites and 209 Comprehensive Environmental Cleanup Responsibility Act (CECRA) priority facilities . The vermiculite mines in Libby, Montana were shut down in 1990. A medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana Department of Public Health and Human Services (DPHHS) has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos-related diseases. According to the Environmental Protection Agency (EPA) in 2010, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

POPULATION CHARACTERISTICS: The U.S. Census reports the 2009 population estimate to be 974,989, 44th in terms of population, with a population density of 6.6 people per square mile. The 2009 population estimates for Montana suggest an overall increase of 8.1% from 2000. The instate population has been redistributing to the western portion of the state and into urban areas over the last decade. The 2008 estimate projects that Montana has six counties with a population over 50,000 people and that 59% of Montanans reside in these six counties. The remainder of the population is dispersed into smaller communities, farms, and ranches . In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2009. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Anticipated population for 2030 is 1,044,898, ranking 27th in the nation for population growth .

AMERICAN INDIAN POPULATION: According to the 2008 Census estimate, there were 62,399 self-identified American Indians in Montana, or about 6.4 percent of the total population. Approximately 37,871 American Indians, or about 57.4 percent, lived on one of the state's seven reservations. The Blackfeet and the Flathead reservations were the largest, with 8,665 and 7,853 American Indian residents, respectively. Rocky Boy's (2,598) and the Fort Belknap (2,805) reservations were the smallest.

AGE: The median age in Montana for 2006-2008 was 39.3 years, higher than the national average of 36.7 years. 6.3% of the Montana population was under 5 years of age and 23% was under 18 years of age, compared to 6.9% and 24.5 % of the US population. Montana's population is split evenly between males and females. According to 2009 U.S. Census Bureau Estimates, women of reproductive age (15-44 years) comprise 17% of the state population .

ACADEMICS: Montana's graduation rate for public high school students for the 2005-2006 school year was 82% compared to the national average of 73%.

Mathematics, Grade 8--the percentage of students in Montana who performed at or above the National Assessment of Educational Progress (NAEP) Proficient level was 44 percent in 2009. This percentage was greater than that in 2007 (38 percent) and was greater than that in 1990 (27 percent). The percentage of students in Montana who performed at or above the NAEP Basic level was 82 percent in 2009. This percentage was greater than that in 2007 (79 percent) and was greater than that in 1990 (74 percent). In 2009, students who were eligible for free/reduced-price school lunch, an indicator of poverty, had an average score that was 22 points lower than that of students who were not eligible for free/reduced-price school lunch. This performance gap was not significantly different from that in 1996 (24 points). In 2009, the average mathematics score in Montana was

- lower than those in 2 states/jurisdictions
- higher than those in 44 states/jurisdictions
- not significantly different from those in 5 states/jurisdictions

Reading, Grade 8-- The percentage of students in Montana who performed at or above the NAEP Proficient level was 38 percent in 2009. This percentage was not significantly different from that in

2007 (39 percent) and was not significantly different from that in 1998 (40 percent). The percentage of students in Montana who performed at or above the NAEP Basic level was 84 percent in 2009. This percentage was not significantly different from that in 2007 (85 percent) and was not significantly different from that in 1998 (83 percent). In 2009, students who were eligible for free/reduced-price school lunch, an indicator of low income, had an average score that was 14 points lower than that of students who were not eligible for free/reduced-price school lunch. This performance gap was not significantly different from that in 1998 (17 points). In 2009, the average score in Montana was

- lower than those in 2 states/jurisdictions
- higher than those in 39 states/jurisdictions
- not significantly different from those in 10 states/jurisdictions

ETHNICITIES: Montana is predominately white with an estimated 90.5% of the 2008 population reporting Caucasian as the primary race, compared to 79.8% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.4% of the total population (62,399), the 5th highest state in the nation.

Census Population	2000	2009 Estimate
White	90.6%	90.5%
Black	0.1%	0.7%
American Indian	6.2%	6.4%
Asian	0.5%	0.6%
Native Hawaiian/ Other Pacific Islander	0.1%	
Two or more races		1.7%
Other	0.6%	

BIRTH & FERTILITY RATES: The Montana birth rate declined from the early 1980s to 1999. The rate of births to Montana residents leveled off and has increased in recent years. It grew to 13.2 per 1,000 residents in 2006 and fell just a bit in 2007 and 2008 to 13.0 . As with many small population states, Montana's health indicators may change dramatically from year to year, leading the public and sometimes policy makers to assume associations between programs and activities and outcomes. In fact, what may appear to be dramatic changes, such as a child death rate dropping to 25 per 100,000 children aged 1-14 in 2005, down from a rate of 33 in 2000, may be due to very small changes in actual numbers.

In 2008, the fertility rate for Montana's white mothers of all ages was 66.2, the birth rate for white mothers between the ages of 15 and 17 was 14.5, and the rate for white mothers between the ages of 18 and 19 was 62.4. Fertility rates for Native Americans were substantially higher in these age groups--107.8, 55.1, and 188.3, respectively. American Indians account for about 6.4% of the total Montana population, and more than 12% of births.

Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites.

INDIAN HEALTH SERVICES, TRIBAL HEALTH ENTITIES & POLITICAL JURISDICTIONS: According to the U.S. Census Bureau designations, the state has 3 metropolitan areas (an urban population core of 50,000 or more) and 5 micropolitan areas (an urban population core of 10,000-49,999). However, the majority of the 56 counties are still considered rural or frontier. Fifty-four county health departments contracted with the DPHHS in FY 2010 to provide Maternal and Child Health (MCH) and other health services. The local health departments are county entities under the control of local Boards of Health and the staff are county employees. The seven Indian reservations are sovereign nations and home to 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common clients between the two service delivery systems.

INDIAN RESERVATIONS and COORDINATION OF SERVICES: The local city/county health departments are contractually required to establish a memorandum of understanding regarding coordination of services with Indian Health or Tribal Health Services, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. Several MCH programs, i.e. Public Health Home Visiting, Cleft Palate Outreach Clinics, are operating on several reservations with a continuing goal to increase the number of partnering reservations.

ECONOMIC ENVIRONMENT

MONTANA WAGES: Among the states with annual pay below the U.S. average, Montana posted the second lowest average pay ($33,305) in 2008. The lowest pay level was in South Dakota ($32,822). The next lowest pay levels were Mississippi ($33,508), Idaho ($33,897) and Arkansas ($34,919). The 2008 average annual pay figures for these states, which account for only 2.8 percent of the nation's workers, were 25 to 28 percent below the national average. Average annual pay levels for 36 states were below the U.S. average in 2008; combined, workers in these states accounted for 52 percent of the nation's covered employment .

FEDERAL AID: Montana taxpayers receive more federal funding per dollar of federal taxes paid compared to the average state. Per dollar of federal tax collected in 2005, Montana citizens received approximately $1.47 in the way of federal spending. This ranks the state 11th highest nationally and represents a rise from 1995 when Montana received $1.46 per dollar of taxes in federal spending (6th highest nationally). Resources supporting state level efforts for the MCH population, including Children & Youth with Special Healthcare Needs (CYSHCN), are overwhelmingly federal. Less than 5% of funding for the Public Health and Safety Division (PHSD), which houses the FCHB, is from the state general fund.

POVERTY: According to the U.S. Census Bureau's Current Population Survey, Montana's estimated poverty rate was 14.1% in 2007, which was above the national estimated poverty rate of 13.3%. Montana had the 16th highest poverty rate in the U.S. in 2007. From 2002 to 2007, Montana's poverty rate varied from a low of 13.6% in 2004 to a high of 14.6% in 2005. The percentage of near poor, those with incomes below 125%, 150% and 200% of the Federal poverty level, was higher in Montana than nationally. Montana counties reporting the highest poverty rates in 2007 include Roosevelt (30.3%), Glacier (26.6%) and Big Horn (26.4%). These three counties had poverty rates that were over 26%, with Roosevelt's rate (30.3%) being over twice as high as the state average (14.1%). Of the 56 counties in Montana, 36 of them held poverty rates above the national average of 13% in 2007. The lowest poverty rates were reported by Fallon (9.3%), Sweet Grass (9.4%) and Yellowstone (9.7%) Counties in 2007.

In 2007, about 15.7% of children under 18 years of age lived below the poverty line in Montana, while about 18% of the same age group lived below the poverty line in the U.S. About 13.2% of Montanans age 18 to 64 lived below the poverty line in 2007, while about 10.9% of this age group lived below the poverty line in the U.S. While 6.7% of individuals age 65 and over lived below the poverty line in Montana, about 9.7% of individuals age 65 and over lived below the poverty line in the U.S. in 2007.

AMERICAN INDIAN ECONOMIC CHARACTERISTICS: Health care and social assistance are the primary employers of American Indians in Montana. These two industries employ about 3,353 American Indians statewide. Public administration (which includes all forms of government) and educational services were second and third, employing 3,200 and 2,660 respectively. The median household income for American Indians was $22,824, far less than the $33,024 reported for all Montanan households. The median household income on the Crow Reservation was $28,199, compared to the $18,484 reported on the Fort Peck Reservation. A closer look at the figures reveals that the Crow Reservation reported by far the lowest percentage in the less than $10,000 income category. Furthermore, there were relatively more households on the Crow Reservation in the middle-income categories from $30,000 to $99,000. These households may

include people with relatively good-paying mining and Bureau of Indian Affairs (BIA) hospital jobs.

UNEMPLOYMENT: In 2009, Montana's unemployment rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2009 was 6.2%, compared to the U.S. rate of 9.3% . Unemployment on the reservations ranged from 8.5% to 16.3%, according to the 2009 Montana Reservation Labor Force Statistics. Data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

AMERICAN INDIAN UNEMPLOYMENT: Annual Average Unemployment Rates on Montana's Reservations

Reservations	2009
Blackfeet	13.8%
Crow	10.5%
Flathead	8.5%
Fort Belknap	Unavailable
Fort Peck	8.8%
Northern Cheyenne	14.0%
Rocky Boy's	16.3%

FACTORS IMPACTING THE MCH POPULATION

ORAL HEALTH: Eleven Montana Community Health Centers (Billings, Bozeman, Bullhook, Butte, Cutbank, Great Falls, Helena, Kalispell, Livingston, Missoula and Libby) include some dental services, though the waiting lists can be long.

Indian Health Service offers dental clinics in:

Browning (Blackfeet Service Unit [SU])	satellite in Heart Butte
Crow Agency (Crow SU)	satellites in Lodge Grass & Pryor
Lame Deer (Northern Cheyenne SU)	
Harlem (Fort Belknap SU)	satellite in Hayes
Poplar (Fort Peck SU)	satellite in Wolf Point
Tribal Programs:	
Box Elder (Rocky Boy SU)	
Polson (Flathead SU)	satellites in Pablo & St. Ignatius

Montana's point-in-time Pregnancy Risk Assessment Monitoring System (PRAMS) in 2002 reiterated lack of access to dental care for pregnant Medicaid participants as a statewide problem. In 2009, 11 counties did not have a dentist and 15 (including the 11) did not have a dentist that accepted Medicaid. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

IMMUNIZATIONS: In 2008, Montana had a 66% immunization rate for children aged 19-35 months who were fully immunized. In 2008, Montana ranked 50th in the nation for series of immunizations given to 19-35 month old children.

MORTALITY: (Rankings: 1=low, 51=high)
High mortality rates are a problem for Montana.

Infant Mortality
2004-2006: 6.0 per 1,000 live births

Death Rate for children aged 1-14 years
2006: 772.9 per 100,000

Five leading causes of death for MT children aged 1-14 years (2006):
1. unintentional injury (32.7%)
2. malignant neoplasms (14.3%)
3. homicide (6.1%)
4. congenital anomalies (4.1%)
5. suicide (4.1%), all others (38.8%)

Five leading causes of death for MT American Indian children aged 1-14 (2006):
1. unintentional injury (40%)
2. malignant neoplasms (20%)
3. suicide (20%)
4. all others (20%)
5. none listed

Death Rate for Total Population (all ages)
2006: 30 per 100,000

Five leading causes of death for total MT population (2006):
1. malignant neoplasms (22.9%)
2. heart disease (22.1%)
3. chronic low respiratory disease (6.8%)
4. unintentional injury (6.6%)
5. cerebrovascular (5.4%)
6. all others (36.1%)

Five leading causes of death for MT American Indian population--all ages (2006):
1. malignant neoplasms (19.9%)
2. heart disease (13.9)
3. unintentional injury (12.9%)
4. liver disease (6.1%)
5. diabetes mellitus (5.3%)
6. all others (41.8%)

In 2006, Montana had a suicide death rate of 19.7 per 100,000 in population.

CHILDREN & YOUTH WITH SPECIAL HEALTH CARE NEEDS (CYSHCN): Montana had an estimated 27,853 children/youth with special health care needs in 2006, up somewhat from an estimated 26,981 in 2001. Examples of conditions that qualify children with special health needs in Montana are: cystic fibrosis, diabetes, cleft lip/palate, asthma, seizure disorder, and juvenile idiopathic arthritis. CYSHCN in Montana may be eligible to receive services from Children's Special Health Services (CSHS), DPHHS. The program's mission is to develop and support systems of care for CYSHCN. The following services are available to eligible CYSHCN and their families: pediatric specialty clinic services, financial assistance, and/or resource referrals. CSHS does not receive any general funds from the state of Montana, it is funded by the Maternal and Child Health Block Grant and revenue received from billing 26 health care agencies for three interdisciplinary clinics (cleft/craniofacial, metabolic and cystic fibrosis).

Effective January of 2008, all newborns are tested for hearing and the 28 conditions recommended by the American Academy of Pediatrics and the American College of Medical Genetics. The metabolic/bloodspot screen follow-up is a contracted service managed by CSHS. The newborn hearing screening program is managed by a staff member in CSHS. This staff person conducts on-site reviews for quality assurance and is continually assessing the needs of the families and partners of the newborn hearing program.

TOBACCO USE, MONTANA YOUTH:

In 2005, Montana introduced the Clean Indoor Air Act (CIAA) that was passed by the state legislature that required schools to be tobacco-free and public places to be smoke-free. The CIAA was fully implemented in October 1, 2009.
In 2009, 12% of high school youth who tried cigarettes before the age of 13, a 10% percentage point decrease from 2001 (29%). During 2009, the highest prevalence was reported for 9th grade students (18%) with the lowest prevalence reported for 12th grade students (8%) who tried cigarettes before the age of 13. Statewide, 50% of high school students had ever tried cigarette smoking (even one of two puffs) during 2009. The prevalence of high school youth who smoked cigarettes on at least one day during the past month decreased from 29% in 2001 to 19% in 2009. Cigarette use was more prevalent among females (20%) than males (18%) during 2009. The use of smokeless tobacco (e.g., chewing, sniffling, or dipping) among high school students decreased only slightly between from 16% in 2001 to 15% in 2009. In 2009, the use of smokeless tobacco was more prevalent among high school boys (24%) than high school girls (4%). In 2009, 55% of high school current smokers had tried to quit smoking cigarettes during the past 12 months.

In 2006, 38% of Montanans were aware that secondhand smoke is a risk factor for SIDS. In 2008, 97% of adults were aware that breathing secondhand tobacco smoke causes respiratory problems in children. Approximately 12% of Montana households with children permitted smoking at any time or any place in the home during 2008. In 2007, 30% of Montana children aged 12 to 17 years who lived in households where someone uses tobacco compared to 28% in 2003. Thirty-three percent of Montana high school students reported being in a car with someone who was smoking in 2008.

OBESITY: In 2007, 12% of Montana children aged 10-17 were obese compared to the national average of 16%. The obesity prevalence among Montana Youth increased over the past several years. The prevalence of obesity among Montana high school students increased significantly from 6% in 1999 to 10% in 2009. In 2009, high school girls had a lower prevalence of obesity (8%) compared to high school boys (13%). In 209, 24% of Montana adults were obese compared to the national average of 27%. The prevalence of obesity among Montana adults increased from 16% in 1999 to 24% in 2009. In 2009, females had a slightly lower prevalence of obesity (23%) compared to males (24%).

HEALTH CARE ACCESS
One Montana Critical Access Hospital CEO always began medical provider recruiting conversations with, "Our town is 70 miles from the nearest McDonald's, 90 miles from the nearest WalMart and 200 miles from the nearest shopping center. Can you handle that?" This description of an isolated Montana community is not unusual. A former Montana U.S. Senator put it this way, "There's a lot of dirt between light bulbs in Montana." Geographic isolation and the long distance between towns and healthcare organizations are often barriers to healthcare access in Montana.

Fifty-four percent of Montanans travel more than 5 miles (one way) to get to a doctor's office; 13% travel more than 30 miles; 7% travel more than 50 miles.

TRANSPORTATION: Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. With little or no public transportation available in Montana's many isolated, rural communities, access to local primary care as well as out-of-town specialty medical services can be a problem. Nearly 96% of Montanans drive themselves or get a ride from a friend when traveling to a doctor's office; fewer than 1% use public transportation (probably because public transportation is found primarily in urban areas and most of Montana is frontier or rural).

INCOME: Montana's lower-than-the-national-average median income adversely affects the

ability of many Montanans to pay for medical care. This is reflected in the 19.1% of Montana's population (nearly 180,000 people) without health insurance.

In a 2003 survey, 12.9% of Montana's adults reported they could not see a doctor in the previous 12 months because of the cost. Examining the survey a little closer, over a quarter (26.3%) of all Montana adults ages 18-64 with a disability--a population that probably needs to see a doctor regularly--had not seen a doctor in the previous 12 months because of cost. Also, over one-quarter (26.7%) of Montanans do not have a personal doctor or health care provider.

AVAILABILITY OF SERVICES: There are ongoing efforts towards the improvement of the availability of an access to health services in Montana. Montana has 45 Critical Access Hospitals, 17 hospitals, 46 rural health clinics, and 37 federally qualified health centers. There are also 56 local county public health health departments and 88 nursing home facilities in Montana. The state has 2353 licensed physicians, 599 active licensed dentists, and 81 psychiatrists.

Healthcare for American Indian residents of Montana is provided by a network of services including: Indian Health Service, hospitals/clinics, county health departments; and private health services. There are three urban Indian full-service medical clinics located in Billings, Great Falls, and Helena and two referral based clinics in Missoula and Butte.

Because of its large geographic size and small population, Montana has 4.3 hospital beds per 1,000 people, ranking near the high end (47th out of 51) in beds-per-1,000-population compared to the 50 states and District of Columbia. However, Montana ranks low (19th out of 51) with 113 hospital admissions per 1,000 people. Montana ranks on the low end (40th out of 51) in the number of nursing homes in the state (again, because of its small population) and 44th out of 51 in the number of nursing home residents.
Although Montana has 76 home health agencies statewide, home health services are not available in 8 of Montana's 56 counties.

HEALTH INSURANCE: According to 2004 Center for Forensic Economic Studies (CFES) data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003, reported the following for the Montana population under age 65: 43% of urban and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. Montana ranked 6th in the nation for hospital expenses per inpatient day at $2,573. In 2003, Montana had 47,088 enrollees in Health Maintenance Organizations (HMO) in 2003, down from 2002.

In November 2008, Montana voters approved the new Healthy Montana Kids program, which expanded coverage under Medicaid and CHIP by raising eligibility levels to 133 percent and 250 percent of the federal poverty line, respectively. The expansion, which went into effect in October 2009, will cover as many as 29,000 of the 34,000 underinsured children in the state.

HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) STATUS 2010:
Montana continues to face a health care worker shortage. Since 2004, Montana has witnessed a net increase in the number of shortage designations. The active HPSA designations in Montana are:

Number of HPSA's in Montana

HPSA Type	2004	2007	2010
Primary Care	57	90	99
Dental Health	42	56	60
Mental Health	35	49	55

As of January 2010, Health Professional Shortage Areas, which included HPSA facilities, were located in all or parts of Montana's 56 Counties as follows:

- Primary Care: 55 out of 56 counties (98%)
- Dental Health: 48 of 56 counties (85%)
- Mental Health: 56 of 56 counties are designated all or in part as a shortage area.

CONCLUSION: As Montana's population continues to age, demand for all occupations -- including those that are now adequately staffed will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of its older-than-average population.

Montana's Title V Program provides leadership and direction for state and local programs and partners to identify issues affecting the health of Montana's MCH population. The 2010 Needs Assessment resulted in the establishment of six Priority Areas and seven new State Performance Measures to better address the current needs of the MCH population. Montana's aging population, geographic challenges, and access to care issues all pose unique challenges to health care delivery for the MCH population. In some counties, local health departments are the sole source of health care for the surrounding population. Montana's Title V funds, which directly support the local health departments in 54 of 56 counties, are critical to meeting the public health needs of the MCH population across the state.

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Senator Conrad Burns, U.S. Senate Floor, December 8, 2004

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From 2004 Montana County Health Profiles. See http://nris.mt.gov/epht/hra.aspx?county=30000&year=2004. The eight counties without home health services are Big Horn, Carter, Golden Valley, Musselshell, Petroleum, Treasure, Valley and Wheatland.

/2012/According to 2010 Census data, Montana saw an increase in total population to 989,415; a slight decline from 6.4 % to 6.3% in the number of American Indian and Alaska Native persons residing in Montana, and slight changes in the racial composition: White persons 89.4%; Black persons, 0.4%; American Indian and Alaska Native persons, 6.3%; Asian persons, 0.6%; Native Hawaiian and Other Pacific Islander, 0.1%; persons reporting two or more races, 2.5%

In SY 2011, the Northern Cheyenne Tribal Health Department elected to not renew their Public Health Home Visiting (PHHV) contract, resulting in PHHV being offered by the Rocky Boy/Chippewa Cree Tribal Health Department and by 14 county health departments.

In SFY 2009, Healthy Montana Kids (CHIP) had 25,298 participants under age 20 enrolled in the program and Healthy Montana Kids Plus (Medicaid), had 63,519 participants under age 20.

State funding remains about 5% of the Public Health and Safety Division's total budget. The 2011 legislature's decision to cut the Montana Tobacco Use Prevention Program (MTUPP) funding in half from 8 million to 4 million will significantly reduce MTUPP's ability to fund outreach to specific populations such as those covered by MCH. A few noticeable reductions will be in cessation benefits available, training for home health nurses, outreach to low socioeconomic status groups, and the policy work for smoke free housing. The FCHB and MTUPP partnership will remain; however, it is unknown at this time, the budget cut's impact on MTUPPs availability for providing smoking cessation training to the PHHV and MIECHV Home Visiting programs.

The attached map illustrates FY 2012 MCH services. //2012//

An attachment is included in this section. IIIA - Overview

B. Agency Capacity

Montana's Title V programs are located in the Department of Public Health and Human Services (DPHHS), the largest agency of Montana's state government, with a biennial budget of about $3 billion. DPHHS has 3,100 employees across the state of Montana, 2,500 contracts and 150 health programs. The programs are housed in one of the 11 divisions of DPHHS. The Title V Program is housed in the Family and Community Health Bureau (FCHB) which is within the Public Health and Safety Division (PHSD), one of the 11 divisions of DPHSS. The FCHB is charged with the responsibility of administrative oversight of the Title V Maternal and Child Health Block Grant (MCH BG). This responsibility includes developing and sustaining collaborative public and private partnerships for the purposes of providing maternal and child health care services to Montana's MCH population across Montana's 145,552 square miles, 56 counties, and 7 Native American reservations.

Statutory Authority for Maternal and Child Health (MCH) Services are found in the Montana

Codes Annotated (MCA 50-1-2020). General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); acceptance and expenditure of federal funds available for public health services; and use of local health department personnel to assist in the administration of laws relating to public health. Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) and Fetal, Infant, Child, Mortality Review (FICMR) are authorized in Title 50.

Rules implementing the above authority are found in Titles 16 and 46 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including children with special health care needs, family planning, school health, and the rules authorizing case management for high risk pregnant women.

The FCHB has a role in ensuring that services and programs to support healthy growth and development are available and accessible to Montana's MCH population. The Bureau budget includes 13 funding sources, of which approximately 96% is federal funding and the remaining 4% is state general fund. The three largest funding sources are from the United States Department of Agriculture for WIC Administration and Supplemental Food; the Department of Health and Human Services Maternal and Child Health Block Grant; and the Office of Population Affairs Title X Family Planning. Additional federal grants, earmarked for specific programs benefitting the MCH population, round out the FCHB yearly operating budget.

Montana's economic situation is similar to that of the other states: a decline in state revenue has resulted in budget cuts for programs allocated state general dollars. The decline in state general revenue as well as the loss of federal funding to support programs (such as the coordinated school health program, the birth defects registry from CDC, the oral health program from HRSA, and the fetal alcohol spectrum disorder prevention program funding from SAMHSA) contributed to diminished FCHB staff and a subsequent reorganization. In May, 2010 the Infant Child Maternal Health Section was combined with the Maternal Child Health Coordination Section, decreasing the number of supervisory staff by one. The Primary Care Office, Public Health Home Visiting Program, FICMR and Targeted Case Management support functions were moved along with 2.5 FTE staff positions into the MCHC Section. In addition, PHSD leadership created an office of Epidemiology and Scientific Support, which will be led by the State Epidemiologist who is presently being recruited. One of the two MCH epidemiologists is moving to the new office of Epidemiology and Scientific Support. The remaining MCH epidemiologist will continue to focus on MCH issues.

As of May 2010, the 36 staff members of FCHB are organized into four sections, one unit, and one office:

- Maternal Child Health Coordination Section (MCHC),
- Children with Special Health Services Section (CSHS),
- WIC Nutrition Section (WIC),
- Women's and Men's Health Section (WMH),
- MCH Epidemiology Unit, and the
- Primary Care Office.

The FCHB is responsible for coordinating the ongoing MCH Needs Assessment process. Included with this application, is Montana's 2010 MCH Needs Assessment, which is a culmination of the past five years of numerous meetings with public and private partners; gathering qualitative and quantitative data; analyzing the data; identifying MCH priority needs, (as well as emerging needs); assessing the State's current resources, activities, and services; and developing state performance measures based on the FCHB's capacity to provide direct health care services, population based services, enabling services, and infrastructure-building services.

In addition to ensuring the ongoing work on the MCH Needs Assessment, each FCHB section

fulfills a role as related to the requirements for receiving the MCH BG. As illustrated on the Agency Capacity Attachment, each section maintains numerous partnerships with public and private entities, which provide preventive and primary care services to the MCH population.

The MCHC Section's primary partners for MCH services are Montana's county health departments. Montana's MCH Administrative Rules of Montana (ARM 37.57.1001) do not require county health departments to accept the MCH Block Grant funding, they can choose to not participate. In FY 2010, 54 of Montana's 56 county health departments accepted MCH funding with the intent of providing MCH services to their populations; two counties opted to not contract with the state to provide MCH services. As part of their contractual obligations, the contracted county health departments select one national or state performance which will be their primary MCH focus. Approximately 42% of the state's MCH BG allocation is distributed to the local health departments.

The MCHC Section also houses the Public Health Home Visiting (PHHV)/ Montana Initiative for the Abatement of Mortality in Infants (MIAMI) Program. The PHHV program is part of the MIAMI act passed by the Montana legislature in 1989. The Legislature has continued to support the PHHV/MIAMI Program with general funds and tobacco trust settlement moneys. The goals of the MIAMI legislation compliment the charges in Title V of the Social Security Act, which are to: 1) ensure that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services; 2) reduce the incidence of infant mortality and the number of low birth weight babies; and 3) prevent the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care.

The PHHV/MIAMI Program has continued to evolve to meet the needs of the MCH population. In Fiscal Year 2010, 14 county health and two tribal health departments provided PHHV services by using a team consisting of a public health nurse, social worker, and dietitian, to provide support and guidance to families who may not be able to access services. Most recently, the PHHV/MIAMI contractors and FCHB staff completed a PHHV reassessment collaborative process whereby changes were recommended to the program requirements. For Fiscal Year 2011, the PHHV/MIAMI contractors will be required to address four outcome measures, which are directly related to the MCH BG: 1) increase the percent of PHHV clients served by the PHHV program who receive adequate prenatal care as measured by the Kotelchuck Index; 2) increase the percentage of PHHV clients who abstain from smoking and other tobacco use during pregnancy; 3) increase the percentage of PHHV infants who are born at a healthy birth weight (2500 to 4000 grams); and 4) increase the percentage of eligible PHHV infants who are exclusively breastfed through 6 months of age.

The FCHB has been selected to provide the leadership and administrative oversight for the state's Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program grant applications. Phase I was submitted on July 9, 2010. and Phase II will be submitted on September 20, 2010. The Bureau has engaged in several stakeholder meetings with the Directors of Montana's agency for Child Abuse Prevention and Treatment, Substance Abuse Services, Head Start State Collaboration Office, and Early Childhood Services as well as with other interested stakeholders that are currently providing home visiting services. These meetings have aided in the state's Phase II application and have laid the foundation for the final phase of implementing the ACA Home Visiting grant in Montana.

The Fetal, Infant and Child Mortality Review Program (FICMR) is also housed in the MCHC Section. FICMR is a statewide effort to reduce preventable fetal, infant and child deaths by making recommendations based on multidisciplinary reviews of the deaths. These in-depth reviews bring together a variety of information from many sources and provide a venue for communities to recognize system shortcomings and create strategies to improve these systems. The prevention of fetal, infant, and child deaths is both the policy of the state of Montana and a community responsibility that was authorized in statute (MCA 50-19-401 through 50-19-406) in

1997. The FICMR process identifies critical community strengths and weaknesses as well as unique health/social issues associated with poor outcomes. In 2005-2006, 53 of Montana's 56 counties and all 7 Indian Reservations participated in FICMR reviews through 30 local FICMR teams. To date, 89% of fetal, infant and child deaths in Montana in 2005-2006 have been reviewed by local teams. A biennial report is prepared and distributed to policy makers. Policy makers review preventable deaths and strategize at community and state levels on how to address FICMR related issues.

To the extent resources allow, the MCHC also addresses the MCH population's oral health needs. One of the two MCHC Health Education Specialists oversees the Open Wide Program, a free online training program initially developed by the National Maternal & Child Health Resource Center, which is accessible to providers who work with the MCH population, i.e. Head Start and child care providers; WIC; public health departments; and school nurses. Montana's Oral Health Education guide was recently highlighted in the National Maternal & Child Health Resource Center, March 2010, Oral Health Resource Bulletin.
The MCHC Supervisor collaborates with the Early Childhood Services Bureau (ECSB), housed in the Human and Community Services Division, who administers the Early Childhood Comprehensive Systems Initiative Grant (ECCS). The ECCS Grant has supported the development and training on a Parent Education and Leadership Curriculum; implementing an early childhood mental health consultation model in child care programs; and ongoing support for 18 Community School Readiness Teams. The MCHC Section also ensures the collaborations and partnerships for addressing those national performance measures which are housed in other Departments. These partnerships include working with the State's Suicide Prevention Coordinator, the Injury Prevention and Immunization Sections, and Healthy MT Kids which operates the MCH toll-free line.

Montana's Children and Youth with Special Health Care Needs (CYSHCN) and their families are served by a number of programs that emanate from the Children's Special Health Services (CSHS) Section, which rejoined the FCHB in January, 2006. Prior to 2006, CSHS was located in the Health Care Resources Bureau of the Health Resources Division. Montana is unique in that blind and disabled individuals, under the age of 16 are automatically eligible for benefits under Title XVI. These individuals are also eligible to receive CSHS services.

Data taken from Montana's 2004 - 2008 MCH Block Grant Annual Reports indicates an average of 4,698 CYSHCN received services from a number of programs overseen by the CSHS. CSHS is responsible for system development and service support for children and youth with special health care needs and their families. This section provides regional clinics, direct pay programs, the newborn hearing and metabolic screening programs, and coordination of the state's genetics program.

CSHS works closely with three Regional Pediatric Specialty Clinics (RPSC) which provide medical care for CYSHCN. The RPSC are in Great Falls, Missoula, and Billings, and outreach clinics are conducted in Bozeman, Helena, and Kalispell as well as on two reservations: Wolf Point and Browning. There are three interdisciplinary clinics: cleft/craniofacial, cystic fibrosis and metabolic. The pediatric specialty clinics vary by region, but include: endocrine, genetics, gastrointestinal, hemophilia, high risk infant, muscular dystrophy, neural tube defect, orthopedic, pulmonary, rehabilitation, and rheumatology.

The Newborn Hearing and Metabolic Screening Program and the Birth Defects Registry was moved to the CSHS section in spring of 2006, in order to promote and coordinate clinical follow up and tracking. CSHS continues to support the development of Children's Health Referral and Information System (CHRIS), a data collection system that is interconnected with the RPSC, MT School for the Deaf and Blind, the MT Medical Genetics program, Healthy MT Kids, Social Security Disability, neonatal intensive-care unit (NICU) referrals, outreach specialty providers and others.

January 2008 witnessed the beginning of the implementation of mandated screening of all Montana newborns for 29 conditions as recommended by national screening standards. CSHS has developed and maintained a partnership with the Department's Laboratory Services Bureau which houses the Newborn Screening Coordinator position. CSHS continues to provide the leadership and administrative oversight of the Newborn Screening Follow-Up Program which is contracted with Shodair Children's Hospital.

Throughout the years, the CSHS staff has focused their efforts to secure Healthy MT Kids (formerly known as CHIP) and Healthy MT Kids Plus (formerly known as Medicaid), and private insurance payments for services provided at their regional clinics, with the revenue being reinvested in the CSHS programs and services. A portion of these funds is used to ensure that patients who are uninsured or under-insured are able to attend the interdisciplinary clinics and that they are not charged. CSHS does not collect co-pays or deductibles from patients attending CSHS interdisciplinary clinics.

CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Their work with Parents Lets Unite for Kids (PLUK), a longstanding advocate for parents and families and the host organization for Montana's Family Voices chapter, centers on collaboration to improve access to community-based, family-centered services for CYSHCN. CSHS also works closely with the entity providing Part C Services, the School for the Deaf and Blind, Social Security Disability, NICUs, school nurses, Vocation Rehabilitation, and the chronic disease program within DPHHS. CSHS also works with case managers from hospitals (in and out of state), insurance companies, and counties.

The FCHB is home to the state's Title X Agency, the Women's and Men's Health Section (WMH) that has historically received a small portion of MCH Block Grant funds to support their partnerships with 14 Delegate Agencies (DA) offering family planning services in 28 locations serving all 56 counties. WMH is responsible for family planning services through Title X supported clinics across the state. The section also monitors and supports community based efforts to prevent teen and other unintended pregnancies.

In FY 2011, WMH will receive $10,000 for their distribution to the DAs for their efforts aimed at preventing teen pregnancies. The DAs provide reproductive health services, technical assistance, and educational and outreach materials targeting low income women and men, including adolescents.

The DAs are also a designated Sexually Transmitted Disease (STD) Program working closely with the Division's STD/HIV Prevention Section. Additionally, each DA is required to employ a medical service provider who provides comprehensive breast and cervical screening services to an identified target population, as well as provide referral services to other programs, i.e. WIC.

Also housed in the FCHB is Montana's Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Section. WIC administers the WIC program in Montana, which offers services through 27 Regional Program contracts with Public Health Departments, hospitals, private non-profits, and tribal organizations with related health or social service programs providing services for all counties in Montana. In 2007, an average of 21, 000 participants per month were provided nutrition assessment and education to improve their eating behaviors; referrals to other health care and social service programs; access to a supplemental food package which now includes fresh fruits and vegetables; and breastfeeding encouragement.

Beginning in 2009, WIC has been involved with developing, implementing, and offering training on MSPIRIT, a new MIS (management implementation system for WIC). It is anticipated that MSPIRIT will provide enhanced data as to the numbers of women initiating breastfeeding, as well as continuing to breastfeed at six months of age and beyond as MSPIRIT links the breastfeeding dyad and food packages being issued. MSPIRIT will also provide data as to the usage of Montana's new WIC Food Package that was rolled out in November 2009. WIC is also the lead

for breastfeeding promotion programs through their oversight of the Breastfeeding Peer Counselor Projects (BPCP). Nine Montana communities were funded and operated throughout the year as a BPCP.

WIC also supports the USDA WIC Farmer's Market Nutrition Program (FMNP), which has been operating in Montana since 2002. FMNP participants receive nutrition education related to fruits and vegetables. The nutrition education includes information on selecting, preparing, best time to buy and nutritional value of fruits and vegetables, and the value of physical activity for a family by shopping at their local farmers' market. In 2007, there were seven local WIC programs participating in FMNP: Custer, Flathead, Lewis and Clark, Missoula, Ravalli, Valley and Yellowstone. The WIC FMNP benefits allow participants to purchase locally grown fresh fruits and vegetables. A total of 5,354 women and children were provided the benefit of $16 in FMNP checks for the market season. Participant and farmer responses to the program have been positive.
The MCH Epidemiology Unit, responsible for overseeing the State System Development Initiative (SSDI) grant, overseeing the 2010 MCH Block Grant Needs Assessment, and submitting the FCHB's Graduate Student Internship Program application, is integral to the FCHB. As mentioned earlier, the PHSD reorganization, upon the hiring of the state Epidemiologist, will result in the present Epidemiology Unit housing the lead MCH Epidemiologist and the FCHB Data Coordinator. Both these positions work closely with the four sections advising on and conducting epidemiological analyses and evaluation projects for the programs administered by the sections. The Epidemiology Unit provides key services for additional grant opportunities that are submitted by the FCHB, and will be a key player in the state's ACA Home Visiting application.

The Primary Care Office (PCO) was incorporated into the MCHC Section in 2009, but continues to operate as a unique program within the Bureau. The Primary Care Office's responsibilities focus on facilitating federal designation of health professional shortage areas, and supporting recruitment efforts for primary care, oral health and mental health professionals. The PCO compliments the efforts of the Bureau staff to promote and support access to quality health care for the MCH population in the state. The PCO and Epidemiology Units provided critical data for the state's April 2010 Grants to States to Support Oral Health Workforce Activities, that if funded will move Montana forward by hiring an external evaluator to perform a thorough assessment of the oral health status and needs of the state and expand the MT Area Health Education Center (AHEC) dental recruitment and retention program.

Maternal and child health services are funded not only by the MCH Block Grant distributed to counties, but by local funding, fees and donations and through programs supported with state general funds. As reported in Montana's MCH BG Annual Reports for 2004 - 2009, direct health care, enabling, population based, and infrastructure services were provided to an average of 97,007 clients per year. As reported in Montana's MCH Block Grant 2008 Annual Report, state funding for genetics, home visiting, and newborn screening follow up resulted in a total state match of $2,173,902. In addition, local partners, primarily local health departments, provided additional match of $3,500,746, and program income (including state and local billing and donations) which totaled $914,508. These amounts, combined with the 2008 federal allocation of $2,462,222 totaled $9,051,378 for MCH Services.

The MCH Block Grant data collected by the FCHB indicates that Montana continues to spend the largest portion of funding on children's services, primarily through contracts with local agencies that in turn provide preventive and primary care services for pregnant women, mothers, infants, and children. The local contractors provide:

- Enabling services, such as health education; family support; assistance with enrollment into Healthy MT Kids or Healthy MT Kids Plus (formerly CHIP and Medicaid); and case management;
- Population-based services such as newborn screening and neonatal follow-up; oral health education; public education on preventable deaths; and immunizations; and
- Infrastructure services such as technical assistance for developing standards of care,

evaluation procedures, and policy development; and training opportunities at the annual DPHHS Spring Public Health Conference.

The CSHS programs and services for CYSHCN expend 30% of the MCH Block Grant. These services are primarily direct health care services such as the medical services provided at the Regional Pediatric Specialty Clinics and the purchase of medical equipment not covered by insurance.

The Governor's Office provides an annual Tribal Relations Training for state employees to strengthen government-to-government relationships and to ensure that participants have a better understanding of state-tribal policies and principles to integrate into their day-to-day work with tribal governments and people. All FCHB Section Supervisors, as well as several other FCHB staff, have attended this training in the last three years. Recently, the Governor's Office also developed an online training program, designed by the federal government, entitled "Working Effectively with Tribal Governments." The training curriculum has been developed to provide government employees with skills and knowledge they can use to work more effectively with tribal governments.

The FCHB organizes and promotes a yearly Spring Public Health Conference. The planning committee has made it a priority for the opening ceremony to be provided by one of the seven Native American tribes in Montana. The Conference also strives to include at least one breakout session which focuses on health concerns associated with Native Americans.

The role of the Health Resources Division (HRD) is to provide health care for low-income and disabled Montanans through Medicaid and the Healthy Montana Kids (HMK) Plan. The HRD provides administration, policy development, and reimbursement for the primary and acute care portions of the Medicaid program. It also provides children's mental health services and health insurance coverage for children through CHIP.

The FCHB's vision is to promote high quality health care services that are delivered in a respectful manner; promote healthy and safe Montana environments (family homes, child care facilities, schools, and communities), and reduce health care disparities within the state. Its mission is "to promote and improve the health and safety of Montana's women, men, children, and families." The FCHB is able to achieve its vision and mission through its ongoing administration of the Maternal Child Health Block Grant and the much needed services this funding provides to the state's maternal child health population.

/2012/Denise Higgins began as Bureau Chief for the Family and Community Health Bureau (FCHB) in December 2010. In February 2011, the FCHB began a series of monthly strategic planning and communication building meetings with the goal of developing a more cohesive bureau responsive to the needs of the Bureau's customers, which include county and tribal health departments, community based organizations, and other governmental agencies within and outside of the Department of Public Health and Human Services.

In the past year, the Public Health and Safety Division (PHSD) added the Office of Epidemiology and Scientific Support, which includes epidemiologists from each of the five Bureaus within the PHSD. The Family and Community Health Bureau's Maternal and Child Health Epidemiology Unit consists of two positions: the Lead MCH Epidemiologist and the Data Coordinator. As of July 2011, the FCHB consists of 35 staff members, with one position vacancy in the Maternal and Child Health Coordination (MCHC) Section, WIC, and the MCH Epidemiology Unit. See the FCHB Organizational Chart attachment in the Organizational Structure Section.

As noted in 2011, the MCHC section within FCHB was designated as the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting (ACA MIECHV) grant administrator. The subsequent required ACA MIECHV grant applications for continued

funding have been submitted to HRSA. The Maternal and Child Health Epidemiology Unit provides support and technical assistance for the ACA MIECHV particularly around the benchmark and construct measures and the continuous quality improvement activities.

Additionally, the MCHC Section submitted an application for one of the ACA MIECHV Development Grants (HRSA 11-179) on July 1, 2011. It is anticipated that the MCHC position vacancy will be advertised with the intent to hire an individual to be responsible for the ACA MIECHV projects. This position would work closely with the Public Health Home Visiting (PHHV) Nurse Consultant who provides oversight to the state's PHHV program, a non evidence based model. In SY 2011, one of the two tribal health departments providing PHHV services declined funds, resulting in PHHV being offered through 14 county and one tribal health departments.

In September 2010, the MCHC filled the position for the State FICMR Coordinator. Also in September, the MCHC received the Notice of Grant Award for the Grants to States to Support Oral Healthcare Workforce Activities. The Primary Care Office will apply for the State Primary Care Offices Retention and Evaluation Activities Under the American Recovery and Reinvestment Act Grant (HRSA 11-201) due August 2011.

The WIC program completed the roll out of M-SPIRIT to all local agencies in January 2010. The system has helped to improve and track services provided by WIC. State staff continues to work with the SPIRIT Users Group to enhance the system to make sure it meets all of the program needs as changes are made in the WIC Program. Data from the system is now able to be used to make program projections and decisions.

In October of 2010 WIC initiated a yearlong outreach project which included statewide bill boards, radio and television advertisements. MT WIC also received a facelift and was rebranded. They developed a new WIC logo and all participant printed materials were redeveloped and distributed to local agencies for use. MT Farm Direct was developed so that the new fruit and vegetable benefits and FMNP benefits could be used at farm stands and farmers markets all across the state. A promotion of "What Incredible Choices" Tool Kit was provided to all Local WIC Agencies to provide ideas and materials for providing education about fruits and vegetables.

MT WIC is completing the planning phase for the transition to EBT from paper benefits. Total implementation is targeted for 2013.

CSHS requested that the Medicaid program conduct a review of non-covered medically necessary items such as over-the-counter vitamins, food thickeners and hypertonic saline, which by is covered by the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. In the coming year, discussions will continue as to how Medicaid can pay when there is no rebate agreement in place for such items. CSHS will continue exploring opportunities to provide additional nutritional services to clients in the regional areas. CSHS is preparing to apply for the 2012 State Implementation grant by conducting a comprehensive CYSHCN needs assessment by December 2011.

Data from Federal Fiscal Year 2010 collected in Child Health Referral and Information System (CHRIS) shows 5529 children and youth with special health care needs received services from the CSHS Section.

The Women's and Men's Health Section filled their Health Education Specialist position in September 2010. As of July 1, 2011, there are now 26 locations with family planning services serving women from all 56 counties. //2012//

An attachment is included in this section. IIIB - Agency Capacity

C. Organizational Structure

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services, which safeguard the health and welfare of Montanans. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." The Director of the Department is Anna Whiting Sorrell, who was appointed by Governor Brian Schweitzer in November 2008. She oversees the agency's 3,100 employees, 2,500 contracts and 150 programs. DPHHS is the largest agency of state government, with a biennial budget of about $3 billion.

The Department of Public Health and Human Services (DPHHS) is a "mega agency" encompassing health and human services for the state of Montana. The Department is organized into the Director's Office and 11 divisions. The Director's Office includes offices responsible for legal affairs, human resources, public information, planning and analysis.

The rest of the Department is organized into 11 divisions:

- Addictive & Mental Disorders -- Develops and implements a statewide system of prevention, treatment, care, and rehabilitation for Montanans with mental disorders or addictions to drugs or alcohol.
- Business & Financial Services - Provides professional services for the management of the Montana Department of Public Health and Human Services.
- Child & Family Services -- Provides services to protect children who have been or are at substantial risk of abuse, neglect or abandonment.
- Child Support Enforcement - Pursues and finances medical support of children by establishing, enforcing, and increasing public awareness of parental obligations.
- Developmental Services - Contracts with private, non-profit corporations to provide services for individuals, and their families, who have developmental disabilities.
- Health Resources - Provides health care for low-income and disabled Montanans through Medicaid and the Healthy Montana Kids (HMK) Plan.
- Human & Community Services - Provides cash assistance, employment training, supplemental nutrition assistance (formerly food stamps), Medicaid, child care, meal reimbursement, nutrition training, energy assistance, weatherization, and other services for needy families.
- Quality Assurance - Monitors and ensures the integrity and cost-effectiveness of programs administered by the department.
- Senior & Long Term Care - Provides information, education, and high quality, cost effective long-term care services for the elderly and disabled.
- Technology Services - Provides operational and technical support to department programs.
- Public Health & Safety -- see below

Jane Smilie is the administrator of the Public Health and Safety Division. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The state's public health system is a complex, multi-faceted enterprise, including partners such as the City/County Health Departments, private medical providers and hospitals, local Emergency Medical Services, Emergency Management agencies and other units of local government. The Division is organized into five bureaus:

- Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
- Communicable Disease & Prevention Bureau -- Jim Murphy, Bureau Chief
- Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
- Laboratory Services Bureau - Anne Weber , Bureau Chief
- Family and Community Health Bureau -- Jo Ann Dotson, Bureau Chief

Maternal and child health services, as described in the Title V of the Social Security Act, are the responsibility of the Family and Community Health Bureau (FCHB). The Family and Community

Health Bureau has a staff of 36 and a total budget of approximately $22 million. The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal programs and WIC. Approximately 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

- Maternal Child Health Coordination -- Ann Buss, Supervisor
- Children's Special Health Services -- Denise Brunett, Supervisor
- WIC/Nutrition -- Joan Bowsher, Supervisor
- Women's and Men's Health -- Colleen Lindsay, Supervisor

The Bureau also has an MCH Epidemiology Unit, led by Dianna Frick, and the Primary Care Office, led by John Schroeck.

An organizational chart of the Montana Department of Public Health and Human Services is available at http://www.dphhs.mt.gov/orgcharts/bureauorgchart.pdf. Organizational charts for the Public Health and Safety Division and the Family and Community Health Bureau are attached as a single document.

/2012/As noted in the updates for Section B: Agency Capacity and Section D: Other MCH Capacity, the FCHB experienced changes in staffing. The MCH Epidemiology Unit consists of the Lead MCH Epidemiologist and FCHB Data Coordinator, a position that is currently vacant. In December 2010 Denise Higgins began as the Bureau Chief for the FCHB. An updated FCHB Organizational Chart is included as an attachment.

The FCHB total federal FY 2012 budget is approximately $25.5 Million, a $3 million increase. Additional federal funding includes the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting, an increase for WIC's SPIRIT project and a reallocation of funds to the WIC Breastfeeding Peer Counseling project, and the Grants to States to Support Oral Health Workforce Activities.

The FCHB manages 134 contracts for FY 2012, the majority being contracts with local health departments and clinical services.

The 2011 Legislative session approved the Public Health and Safety Division 2013biennial budget request at approximately $3.1 million or 2.4% less when compared to the 2011 biennium. For more information go to: http://leg.mt.gov/css/fiscal/reports/2011-session.asp#ba2013

Information about the Department of Public Health and Human Services can be accessed at: http://www.dphhs.mt.gov/
//2012//

An attachment is included in this section. IIIC - Organizational Structure

D. Other MCH Capacity

The MCH BG supports 13.5 FTE at the state level in FFY 2010. Staff supported by the MCH BG are located in the MCHC and CSHS Sections, and in the MCH Epidemiology Unit. The Bureau Chief's salary is cost allocated to all programs and sections, based on the number of staff in the program. Other funding sources supporting staff in the FCHB include other federal funds (WIC, Title X, Newborn Hearing Screening and SSDI) and some general fund and state special revenues.

Key Title V staff in Montana include:

Jo Ann Walsh Dotson, RN, PhD -- Bureau Chief. Dr. Dotson has been the Bureau Chief of the FCHB since December of 1997. Dr. Dotson was an inpatient and outpatient pediatric nurse, and a faculty member in the College of Nursing at Montana State University prior to working for the state. Dr. Dotson's 2009 dissertation evaluated the home visiting program in Montana. Dr. Dotson is retiring from state government in the summer of 2010 -- the position will be recruited with a target start date of fall of 2010. On July 1, 2010 Joan Bowsher, WIC Director, was appointed as Acting Bureau Chief for the FCHB.

Ann Buss, MPA -- MCHC Supervisor. Ms. Buss has been the MCHC supervisor since 2006. She oversees seven staff responsible for general MCH service contract support, public health home visiting, oral health promotion, primary care recruitment and retention and bureau financial and administrative support. Ms. Buss completed her MPA in 2008 and the MCH Certificate program through RMPCH in 2009. She is a member of the Directors' Strategic Planning Committee, and represents the division on the Interagency Coordinating Council for Women. Ms. Buss is also a member of the Legislative and Finance Committee of AMCHP.

Denise Brunett, BA -- CSHS Supervisor. Ms. Brunett has been the CSHS supervisor for two years. She oversees five staff and a contracted staff member responsible for the newborn screening and genetic programs, the regional clinics and CYSHCN referral services. Ms. Brunett represents the division on the HIPAA workgroup

Dianna Frick, MPH -- Lead MCH Epidemiologist Ms. Frick has led the Epidemiology Unit for two years. Ms. Frick has routine meetings with the medical officer who also serves as the state epidemiologist; a new position for a state epidemiologist was created and is presently being recruited to oversee a new Division level office of Epidemiology. One of the two MCH Epidemiologists, Dorota Carpenedo, is being moved to the new office once the lead position is filled. Ongoing coordination of the work of the MCH epidemiology unit with the new office will be needed over the coming years.

Montana CSHS has a CSH Committee that according to its charter, provides crucial input to the program regarding family concerns and needs. On this committee are three parents of children with special health care needs. At this time their involvement has been their attendance at committee meetings. The CSHS manager will continue to encourage as well as financially support their expanded participation for attending conferences and other appropriate training opportunities. (See attached CSHS committee charter in National Performance Measure 2)

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated; cost allocation has increased annually for the last several years. In addition, administrative rule and MCH Service contracts allow county health departments to use up to 10% of the funds allocated to them for administrative purposes.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. Approximately 41% of the MCH BG received by Montana is distributed to counties through MCH contracts. In FY 2010, 54 of the 56 counties were funded and for FY 2011, an additional county indicated a desire to provide MCH services. Those amounts are based on an allocation formula that considers target population and poverty levels. The funding impacts the amount of time and subsequent work which may be "purchased" with the dollars -- some of the smallest counties receive only $1,500 per year. The funding does require that a designated individual be available to monitor MCH needs; the MCH BG helps support a portion of those positions, and in cases, provides the "anchor" or designated funding for public health in the county.

The Health Resources Division maintains a Family Health Line. Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line on which Montanans can access information about health care programs for

children and other health issues sponsored and promoted by the Department. Most of the calls received on the Family Health Line are related to HMK (the Children's Health Insurance Plan), but training has been provided to staff who answer the line to ensure that they are aware of programs to which families may be referred, including, but not limited to CSHS. See the attachment for the FCHB/MCH script.

2012/Denise Higgins, BS-- Bureau Chief. Ms. Higgins has been the Bureau Chief of the FCHB since December of 2010. She holds BS is in Medical Technology from Illinois State University and is certified by the American Society of Clinical Pathologists. Ms. Higgins was the Newborn Screening & Serology Laboratory Manager for the Montana Public Health Laboratory at DPHHS. She was originally hired by the Montana Department of Public Health & Human Services to develop Montana's birth defects registry and conduct Newborn Screening follow-up. She has also coordinated laboratory bioterrorism activities and served as the Departments Planning Chief for the DPHHS Incident Command Team.

Through vacancy savings and the combining of two sections into one section, Montana maintained allocating approximately 41% of the 2010 and 2011 MHC BG amount to the local health departments based on the allocation formula as previously mentioned. The 2012 Pre-Contract Survey results indicate that Liberty County has opted to decline their 2012 MCH BG allocation, bringing the total to three counties declining MCH BG funds. The remaining 53 counties will receive approximately 41% of the anticipated 2012 funding amount, with the smallest counties continuing to receive the $1500 minimum amount.

The MCHC Supervisor, Bureau Chief, and FCHB Financial specialist analyzed the FCHB FY 2012 salary projections and determined that for FY 2012, 10.1 FCHB/FTEs would be supported with MCH BG funding. The FCHB received additional funding through the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program (ACA MIECHV) and from the Grants to States to Support Oral Health Workforce Activities grant opportunities.

The 18 member CSHS Advisory Committee, which includes three parents, has a charter membership and delineates the committee members' roles for their participation. Their two 2012 meetings will include local community CYSHCN service providers presenting information about their function in providing services to the CYSCHCN families.

CSHS parents also participated in several additional opportunities in the past year. The Helena area parent representative attended CSHS staff meetings, regularly met with CSHS staff and provided feedback on projects and pamphlets. An additional parent was sponsored to attend the National Early Hearing Detection and Intervention (EHDI) conference in February of 2011. This parent representative continues to provide program feedback, working with CSHS staff and the newborn hearing program physician champion. Another parent, who is not a CSHS Committee member, is involved with CSHS' cystic fibrosis services and attended the June 2011 CSHS Committee meeting and shared feedback about CSHS cystic fibrosis clinic services.

The CSHS manager will continue to encourage, as well as financially support their expanded participation for attending conferences and other appropriate training opportunities. (See attached CSHS committee charter in National Performance Measure 2).//2012//

E. State Agency Coordination

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a manageable process. The fact that a few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow and many clients are served in common. Local input is regularly sought at the state level and is usually in the form

of advisory councils, committees and/or functional work committees.

The Bureau structure facilitates excellent coordination between WIC, Family Planning and MCH Programs. The Bureau organizes and sponsors the Spring Public Health Conference, which provides an excellent opportunity for cross-training between local program staff. Bureau staff also work closely with staff in other bureaus, divisions and sections to address national and state performance measures. Examples of partnerships include coordination of programming to address childhood immunization rates with the immunization program, collaboration with the Health Resources Division on the Family Health Line, and referral of Medicaid and Children's Health Insurance Program (CHIP) families to CYSHCN as needed. Bureau staff participates on advisory groups such as the Montana Council for Developmental Disabilities and includes Family Voices representatives on the Children Special Health Services committee.

The Partnership Diagrams, included as an attachment for the Agency Capacity section, illustrate the Bureau's numerous collaborations with state and private human services agencies across Montana. These partnerships enhance as well as support the Bureau's programs addressing the health care needs of the MCH population, which are reflective of the priority health care needs and performance measures established for 2010.

/2012/The FCHB continued their relationships with their partners as originally stated in 2011. Additional partnerships, illustrated in the Section B: Agency Capacity attachments have been added in the previous year.

Several grant opportunities, such as the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program (ACA MIECHV), Grants to States to Support Oral Health Workforce Activities, and the Montana Best Beginnings State Advisory Council have contributed to the expansion of state, private and community based partners. The ACA MIECHV has resulted in the formation of the ACA MIECHV Agency Work Group, which meets twice a month. This work group is composed of directors of the state's agencies for Title II of the Child Abuse Prevention and Treatment Act (CAPTA); Substance Abuse Services; Child Care and Development Fund (CCDF) Administrator; Head Start State Collaboration Office; State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act; and the Injury Prevention Program. The Grants to States to Support Oral Health Workforce Activities has generated a relationship with the Montana State University/Area Health Education Center (AHEC) to expand educational programs to promote oral health professions by AHEC staff visiting Montana's secondary schools.

Bureau staff members participate on established DPHHS committees and workgroups, such as the WIC Future Study Group and the Injury Prevention Coalition. Staff members have also been invited to participate on new committees, i.e. Western-States Child Death Review Coalition, the DPHHS Director's Office Best Beginnings Strategic Communications Work Group, and the Montana Healthcare Workforce Advisory Committee. Participation on these committees supports the Bureau's educational outreach efforts about the impact that the Title V/MCH Block Grant has on Montana's women, infants, children and families.

The Spring Public Health Conference has been renamed the Family and Community Health Conference. The Children's Health Insurance Program is now the Healthy Montana Kids program//2012//

F. Health Systems Capacity Indicators

Introduction
Montana continues to asses the indicators and data sources for the Health Systems Capacity Indicators (HSCIs) on an annual basis. The Health Systems Capacity Indicators most relevant to the state are used throughout the year to summarize aspects of maternal and child health. The State Systems Development Initiative (SSDI) makes a significant contribution to Montana's ability to report on and interpret data for the HSCIs by facilitating employment of a lead MCH Epidemiologist. The epidemiologist position is responsible for the annual assessment of data sources used for the block grant and exploration of new sources.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	24.9	19.8	18.8	17.6	17.6
Numerator	145	118	115	110	110
Denominator	58191	59581	61292	62438	62438
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data for 2010 are from 2009 to Montana Residents. Data for 2010 will become available mid year in 2011. Data are provided by the Montana Hospital Association. Hospital discharge data are limited to Montana occurrences and reporting hospitals.

Notes - 2009
Data updated for 2011 submission. Data are provided by the Montana Hospital Association. Hospital discharge data are limited to Montana occurrences and reporting hospitals.

Notes - 2008
Data updated for 2011 submission. Data are provided by the Montana Hospital Association. Hospital discharge data are limited to Montana occurrences and reporting hospitals.

Narrative:
Medicaid claims data were used as the data source prior to 2005, although the records included only represent a subset of Montana's pediatric population. As of 2005, hospital discharge records are used as the data source for this indicator. Hospital discharge records that are available are currently considered a more complete source of data for this indicator than Medicaid. Although the quality of the limited hospital discharge data that are available continues to improve, a bill introduced in the 2009 legislature to require hospital reporting of discharge data did not pass.

Montana's Title V program does not have an asthma component, but the program does collaborate with projects related to asthma and healthy environments. Previously, Montana's Environmental Public Health Tracking (EPHT) Project is working with communities to identify the primary environmental health risks, some of which are possible risk factors for asthma. However, in 2006 the Environmental Public Health Tracking Project was not funded and the tracking activities have ceased. The 2007 Montana Legislature approved the use of general funds for asthma surveillance and control. As a result, the Chronic Disease Bureau of MT DPHHS recently initiated an asthma program and hired a coordinator. A report on the burden of asthma in Montana was released in 2007. A "Montana State Asthma Plan" was released in March 2009,

developed by the Montana Asthma Advisory Group. The advisory group, formed in January 2008, includes over 30 individuals representing 25 agencies and organizations, including the Title V program, and works to coordinate asthma control efforts in the state. The plan describes strategies to improve surveillance systems, partnerships, and services for children with asthma. In particular, the plan calls for legislation to require hospital discharge data reporting.

The most recent National Survey of Children's Health (NSCH), with data from 2007, did not include a question about asthma-related hospitalizations as it did in 2003. It did measure prevalence, with 6.6% of Montana children 0-17 currently having asthma, as compared to 9.0% nationally. In addition, 3.3% of Montana children had asthma in the past but not at the time of the survey, compared to 4.5% of children in the U.S. While the NSCH data show that children in Montana have lower rates of asthma than the rest of the country, the actual prevalence of asthma in the state may be higher than reported. The survey question asked if a healthcare professional had diagnosed the child with asthma, so limited access to healthcare (an identified problem in the state) may influence the prevalence measure.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	91.9	88.0	92.7	88.6	91.2
Numerator	1160	4717	5118	4883	4199
Denominator	1262	5359	5520	5510	4606
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2010
Data are from the EPSDT CMS-416 Report for FFY2010. For the numerator and denominator, the reporting has been changed to be more specific and is now counted as "total individuals eligible for EPSDT for 90 continuous days."

Notes - 2009
Data are for FFY 2009 from the EPSDT report from the Montana Medicaid Program.

Notes - 2008
This data for FFY 2008 came from the EPSDT report from the Montana Medicaid Program on 4/22/09.

Narrative:
Montana's Medicaid program is in a different division of the MT Department of Public Health and Human Services than the state's Title V program. Collaboration does occur where appropriate around MCH-specific activities. For instance, the Children's Special Health Services (CSHS) section collaborated with Medicaid's PASSPORT program to promote the awareness of the medical home concept for CSHCN. Newborn screening also occur for the majority of Montana's newborns, regardless of whether they are Medicaid enrollees or not.

The denominator for 2006 was updated by Medicaid on March 9, 2009 resulting in change in the

Annual Indicator from 22.7 to 91.9 for that year. 2006 data are considered to be an anomaly. In the most recent three years, the indicator shows an average of 90% of Medicaid enrollees receiving at least one screen.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	0.0	0	0	0	0
Numerator	0				
Denominator	1				
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
Data are not available for this indicator. Montana's CHIP program does not currently collect data that can be used for this Health System Capacity Indicator. The Family and Community Health Bureau continues to collaborate with CHIP on the possibility of reporting on this measure in the future.

Notes - 2009
Data are not available for this indicator.

Notes - 2008
Data are not available for this indicator.

Narrative:
Montana's CHIP program does not collect data that can be used for this Health System Capacity Indicator. The Family and Community Health Bureau continues to collaborate with CHIP on the possibility of reporting on this measure in the future. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids was implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level. Although this change may not affect Montana's ability to report on this capacity indicator, it is expected to increase the number of children who receive health care and screenings through the CHIP program.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	78.8	78.7	59.7	59.7	59.7
Numerator	9818	9772	7498	7498	7498

Denominator	12462	12414	12567	12567	12567
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2010
An estimate is provided based on the 2008 data. The indicator will be updated when the analysis is conducted of 2010 data later in 2011.

Notes - 2009
The data are from 2008. 2009 data were not available at the time of grant submittal. They are expected by be available later in 2010.

Notes - 2008
Data for this measure for 2008 should not be compared to prior years due to changes in the way the data are collected. The data source for this measure is the Montana Office of Vital Statistics. Both the numerator and the denominator reflect data on live births to Montana women 15-44 years of age, regardless of the place of occurrence. A new birth record format was implemented in 2008, following the 2003 revisions to the US Standard Certificate of Live Birth. The new birth record revised the way data on prenatal care initiation are reported. Also, due to the change the number of records with unknown or missing data increased. In 2008, the percent of births with unknown timing of prenatal care was 6.5%, compared to <1% in previous years. Among births with known prenatal care, 63.8% were less than or equal to 80% on the Kotelchuck Index.

Narrative:
In 2008, Montana adopted the new birth certificate format (2003 revision of the U.S. Standard Certificate of Live Birth). 2008 data should not be compared with data from previous years due to the changes in the way the data are collected. The substantial decrease in early prenatal care initiation is believed to relate to the new birth record format and the change in the way the data are collected. Other states have experienced the same drop when the new format was implemented.

As the National Center for Health Statistics (NCHS) noted in Births: Final data for 2005, "Prenatal care data based on the revised certificate present a markedly less favorable picture of prenatal care utilization than those based on the unrevised certificate. For the first year the new certificates are implemented, the percentage of women reported to begin care in the first trimester typically falls in a state by at least 10 percent. Much, if not all of this decline is clearly related to changes in reporting and not to changes in prenatal care utilization. In brief, the revised item asks for the exact "date of the first prenatal visit," and the instructions recommend that the information be collected directly from the mother's prenatal care records. The 1989 Certificate, in contrast, includes the less specific "month of pregnancy prenatal care began" (e.g., 1st, 2nd, 3rd), and no source for these data is recommended. " From: Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol 56 no 6. Hyattsville, MD: National Center for Health Statistics. 2007.

Also, 6% of 2008 records have "unknown" timing of prenatal care initiation, a large increase from the approximately 2% reported in previous years. This is expected to improve in subsequent years as hospitals and staff become more familiar with the new birth certificate format. Among births with known prenatal care, 63.8% were less than or equal to 80% on the Kotelchuck Index. More complete data in subsequent years will indicate whether the unknowns resulted in an underestimate of the actual number of women with adequate prenatal care.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2006	2007	2008	2009	2010
Annual Indicator	86.1	97.5	93.4	91.0	91.0
Numerator	51200	61532	58450	60207	70888
Denominator	59448	63136	62553	66147	77901
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010

The numerator includes children 1 through 19 years who received Medicaid benefits during 2010 calendar year. The data are pulled by child's DOB and are an unduplicated count. Data source for the numerator is MT Medicaid Querypath. The denominator are Montana children 1 through 19 years who are below 133% FPL. Data source for the denominator is US Census data via the CPS Table II. Census data were collected in year 2010 and reflect alternative poverty status in 2009

Notes - 2009

The data source is the Montana Medicaid Program data, via QueryPath.
The data include for any children who were eligible for Medicaid during any part of the fiscal year and were less than 19 years of age. Providers have up to a year to submit claims. All claims for FFY 2009 have not been processed and the actual percentage of recipients with a claim may be higher.

Notes - 2008

The data were updated for the July 2010 submission.
The numerator and denominator were obtained from Medicaid Program.
The data include any child that was eligible for Medicaid during any part of the fiscal year and was 18 or under at the start of the fiscal year.

Narrative:

Montana's Maternal and Child Health program has limited influence over Medicaid-provided programs. Several MCH programs collaborate with Medicaid to try to increase care or educate Medicaid providers and program staff on possible services and interventions. For instance, the WIC and Children's Special Health Service (CSHS) programs both assist their clients to verify whether they are eligible and initiate enrollment in Medicaid where appropriate. CSHS, the MCHC section and the Oral Health Education Specialist have all developed relationships with Medicaid to collaborate on programs that will help serve children and facilitate their access to Medicaid services. Montana struggles with access to providers, particularly providers who will accept Medicaid, which certainly affects this indicator. As populations within the state shift towards larger population centers, rural areas are having more difficulty recruiting and keeping providers.

Transportation challenges and distances involved in getting to a health provider can deter families from using services. In some of the state's population centers, providers are over-booked and it may be a challenge to find a physician accepting new patients or Medicaid-eligible clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

The same data source was used for 2009 as for previous years. In 2006 there was a slight drop in the Medicaid-paid services, but the numbers increased in 2007. The indicator decreased again in 2008 and 2009, although 2009 data are not yet final, so the indicator may be an underestimate.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	33.4	39.7	52.2	38.6	45.1
Numerator	4099	4897	6406	5112	7356
Denominator	12279	12320	12269	13231	16314
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
Data are from the EPSDT CMS-416 report MT Medicaid Program for FFY2010. The numerator is eligibles receiving any dental services (6-9); the denominator is total individuals eligible for EPSDT.

Notes - 2009
Data are from the EPSDT report from the Montana Medicaid Program for the FFY 2009.

Notes - 2008
This data are from the FFY 2008 EPSDT report from the Montana Medicaid Program.

Narrative:
Montana's maternal and child health (MCH) program has limited ability to affect Medicaid programs. However, the Oral Health Education Specialist (within the MCH program) continues to collaborate with Medicaid on dental access issues. Montana struggles with a shortage of dental professionals in the state. The shortage is even more severe in rural areas and when considering dentists who accept Medicaid and child clients. For children with behavioral problems or special needs, finding a dentist who will accept them as a client can be even more challenging. Montana continues to experience shortages in dental health professionals overall, and particularly in health professionals who serve Medicaid clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid

and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids was implemented October 1, 2009 and expanded eligibility to 250% of the federal poverty level.

The number of EPSDT-eligible children 6-9 years old who received dental services increased substantially in 2008, and then appeared to decrease in 2009. The increase in dental services in 2008 could be related to an increase in Medicaid dental provider rates that went into effect in October of 2007. Dental provider rates were increased from 64% of charges for children to 85% of charges in the aggregate. The reasons for the drop in 2009 are unknown. Montana continues to experience shortages of health professionals overall, and particularly health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2006**	**2007**	**2008**	**2009**	**2010**
Annual Indicator	0.0	0.0	0.0	0.0	0.0
Numerator	0	0	0	0	0
Denominator	1	1	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2010
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid. The guidance for this measure was clarified with HRSA prior to the MCH Block Grant submission in 2009.

Notes - 2009
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

Notes - 2008
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

Narrative:
During a review of the guidance for this indicator, and discussions with the Montana Children's Special Health Services Program, it was determined that no children meet the criteria to be reported in the numerator for HSCI 8. The guidance states the goal of this HSCI as "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is

not provided by Medicaid." In Montana, all children eligible for SSI are also eligible for Medicaid. From 2006 to 2009, no SSI beneficiaries under 16 in Montana received services through the CSHCN program that were not paid for by the Medicaid program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2009	payment source from birth certificate	8.4	6	7.1

Notes - 2012
"All" includes those with unknown payment source for delivery. Data are for 2009 births.

Narrative:
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. The overall rate of low birth weight in 2008 is 7.4%. The low birth weight rate among Medicaid-paid births is 8.6%. Among the non Medicaid-paid births, the rate is 6.7%. However, if the births with an unknown payer source are excluded from the non Medicaid group, the low birth weight rate drops to 6.3%. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2009	matching data files	8	4.1	5.6

Notes - 2012
"All" includes those with unknown payment source for delivery. Data are for 2009 births. These data are considered preliminary. Linked birth-death records that include delivery payment source may be available later in 2011, depending on the availability of vital statistics staff time to link the data sets.

Narrative:
A new birth certificate was implemented in 2008 that collects payment source for births. As of 2008, Montana collects primary source of payment as a part of the live birth record. In 2008, 30% of births were paid by Medicaid. Linked birth-death records using the new birth record format may

be available in late 2010. Linked birth-death-Medicaid files have suggested the rate of infant death among Medicaid paid births is significantly higher than among non-Medicaid births. However, due to the inability to verify some of the required information, the linked data files are not used as a source for this measure.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	payment source from birth certificate	58.5	74.3	65.7

Notes - 2012
"All" includes those with unknown payment source for delivery.

Narrative:
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. Overall, 71.3% of women who gave birth in 2008 began prenatal care in the first trimester.

Among Medicaid-paid births, 65.7% of women started prenatal care in the first trimester. Among the non Medicaid-paid births, the rate is 73.7%. However, if the births with an unknown payer source are excluded from the non Medicaid group, the percent of women who started prenatal care in the first trimester increases to 78.9%. Among births with an unknown payer source, only 42.5% started prenatal care in the first trimester. However, timing of prenatal care initiation was unknown for 40.1% of the births with an unknown payor source. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate	2008	payment source from birth certificate	55.7	61.4	59.7

prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					

Notes - 2012
Data are reported for 2008. Updated data for 2009 and 2010 are expected to be available later in 2010.

Narrative:
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. Overall, 6.5% of births had unknown adequacy of prenatal care. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid. Overall, 59.7% of women 15-44 years of age who gave birth in 2008 had adequate prenatal care. Among Medicaid-paid births, 55.7% of women had adequate prenatal care. Among the non Medicaid-paid births, 61.4% had adequate prenatal care. However, if the births with an unknown payer source are excluded from the non Medicaid group, the percent of women with adequate prenatal care increases to 66.1%. Among births with an unknown payer source, only 32.7% reported adequate prenatal care and 38.1% had unknown prenatal care adequacy. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2010	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2010	250

Narrative:
These data come from the state Medicaid and SCHIP programs. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's**	**YEAR**	**PERCENT OF POVERTY LEVEL**

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		**Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2010	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2010	250

Narrative:
These data come from the state Medicaid and SCHIP programs. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2010	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2012
Montana's SCHIP (CHIP) does not cover pregnant women unless they are under 18 years of age (covered under CHIP as children).

Narrative:
These data come from the CHIP and Medicaid programs. In 2007, the Medicaid eligibility level for pregnant women was increased from 133% to 150% of the federal poverty level. In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP (HMK/CHIP). HMK/CHIP was implemented October 1, 2009 and the eligibility was expanded to 250% of the federal poverty level. However, no provision for increased coverage of pregnant women was included in the bill or legislation. Enrollment has been slower than expected, but the number of children enrolled continues to increase.

Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

According to the latest Title V Information System (TVIS) data (reported by states in 2009), only 11 states had Medicaid eligibility levels for pregnant women lower than Montana's.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	2	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	1	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	Yes

Notes - 2012

Narrative:
The Family and Community Health Bureau (FCHB), Montana's Title V Program, does not have purview over the majority of the databases and surveys mentioned, with the exception of WIC, PRAMS, newborn screening, and the birth defects surveillance system. Therefore, while the Bureau is often involved in discussions regarding vital statistics data and linkages, it may not be the decision-maker.

Montana's Office of Vital Statistics links birth and death record files annually when the datasets are finalized and staff time are available.

Montana's new SPIRIT WIC data system was implemented in late 2009. Linkage of birth certificate data to WIC data is an objective within the next five years.

Montana's newborn screening system has been updated to accommodate the changes in the birth record format for 2008 births and allow for linking of records.

A bill introduced in the 2009 legislature to require hospital reporting of discharge data did not pass. However, several years of data are available with some limited use to the MCH program and the data quality continues to improve.

Montana has birth defects surveillance data through 2005. Active collection of birth defects data was suspended in 2005 when the newborn screening grant application to CDC was approved but unfunded. Discussions continue regarding possible future methods of collecting and using birth defects data. All of the data collected thus far are maintained by FCHB.

Montana received a PRAMS grant for a Point-in-Time survey in 2002. The funding application for a PRAMS grant in 2006 was not successful. Montana's 2011 PRAMS application was approved but unfunded; unfortunately no new PRAMS states were funded in 2011. The 2002 PRAMS data are maintained by FCHB. At this time, FCHB is unable to conduct an independent PRAMS-like survey due to funding and staff limitations. However, possible additional and alternative data sources continue to be explored.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2012

Narrative:
Montana's Office of Public Instruction (OPI) conducts and maintains the data from the Youth Risk Behavior Survey (YRBS). The YRBS has been conducted in Montana every other year since 1993, with the most recent results available for 2009. Montana's Title V program frequently uses YRBS data for grant applications and reports, and it is a valuable source of information for the five-year maternal and child health needs assessment.

As of 2008, the raw YRBS data are available to the MCH program. 2009 is the most recent year available.